Montana
Department of Labor and Industry
Business Standards Division
Governor Brian Schweitzer

PROPER MANAGEMENT OF PATIENT RECORDS WHEN CLOSING AN OFFICE

Unprofessional conduct rules for physicians state: (u) “Failing to transfer pertinent and necessary medical records to another licensed health care provider, the patient or the patient's representative when requested to do so by the patient or the patient's legally designated representative.”

When closing an office, provide written notice to patients several months in advance (Rhode Island recommends 60-90 days), provide a local repository or custodian for patient records, make some arrangements with nearby providers respecting on-going psychotropic medications or other treatments, etc. Many physicians terminating a practice contact their malpractice carrier to determine if the carrier has any particular requirements in order to better defend the physician in any subsequent malpractice actions.

Enclosed, please find a Medical Records Questions and Answers sheet.

Finally, I have enclosed for your reference a copy of a recent decision by the Montana Board revoking the license of a physician who left the state without making appropriate arrangements for transfer of patient records, among other things. This decision, as all Board actions, was reported to the National Practitioner Data Bank, the Federation of State Medical Boards, and was provided to the local Montana Newspaper and the Medical Board of the state to which the physician had moved. Most states have statutes which provide for reciprocal discipline.

MEDICAL RECORDS
QUESTIONS AND ANSWERS

Q. How long must I store my patients' medical records?

A. The purposes of keeping patients' medical records are to insure the continuity of care for the patient and to protect the physician against allegations of malpractice. There is no statute mandating the length of time a physician must keep a patient's record. For active patients, obviously you'll need ready access to the record. But for inactive or relocated patients, the issue isn't as clear. The Medical Malpractice Joint Underwriting Association of Rhode Island recommends 10 years after the date of the last patient contact. This covers the three year tort statute of limitations plus the period of liability if the malpractice was discovered by the patient after the statute of limitations has elapsed. Hospitals and obstetricians have heightened considerations and may wish to extend significantly the storage period.

Q. What do I do with my patient records if I retire or move to another state?

A. A physician has a continuing responsibility to make records available to patients for continuity of care purposes. Retiring physicians often sell a practice to another physician, group, or corporate entity. Usually, the records are transferred following the closing of the transaction. Responsible and caring physicians take steps well in advance to inform the patients of their intentions and give the patient the opportunity to have the record transferred to a physician of the patient's choice. Others make a copy of the chart available directly for the patient. Advertisements in the general circulation newspaper and perhaps a direct mail letter to the patients are the preferred method. Physicians are permitted to charge a reasonable fee for retrieval, copying and transfer of the record. This should not be viewed as a fund raising opportunity. This will lead to complaints and massive dissatisfaction.

Some physicians choose to store their patients charts at home in an attic or garage and keep busy handing requests for transfers. Most, however, view storage and retrieval as a headache. Commercial storage and retrieval companies can handle the process for you. Usually, the physician pays a one-time fee and the per request transfer fees are paid by the patient.

Q. If a patient has an outstanding bill, can I insist upon payment before I transfer the record to the new doctor?

A. No. First of all, you don't want to be liable for injury to the patient as a result of your failure to act. Secondly, your collection problems are civil matters outside of your primary patient responsibilities. A patient's bad manners are not going to go far to excuse your negligence. Record transfer and billing issues seem to prompt complaints to this board.

Q. When a patient requests a record which contains records obtained from a previous physician, must I forward the previous physician's record along with the record of my treatment?

A. When a physician's record contains reports and records obtained from the patient's previous physicians those other records are merged into the new record and a physician must transfer all of the medical information. Remember that the patient already signed a release for a record transfer in order for you to obtain the record. Physicians should check the records carefully and, perhaps, with the prior doctor to make sure the proper releases have been executed. The presence of psychiatric reports may affect the transfer.

exercise self control or judgment are affected by a new law. R.I.G.L. 40.1-5-27.1 provides that, upon a written request by a family member or other person caring for the disabled person, the mental health professional may disclose certain informa-

NOTICE

Several physicians have expressed concern over the Board's categorizations as "RETIRED" for the physician who has reached age 70 and has

Child Abuse in Oklahoma

by Gerald C. Zumwalt, M.D.
Board Secretary/Medical Advisor

The Oklahoma Department of Human Services recently released a report on statistics of child abuse and neglect for fiscal year 1996.

It is, of course, appalling in the sheer numbers. In 1996, 44,879 referrals of possible abuse and neglect were received. 40,916 cases were investigated and 11,646 cases were confirmed. As expected, the largest number occurred in Oklahoma and Tulsa counties but the report does not break down the occurrences per 1000 population so the significance of those numbers is blunted. (Only one case was confirmed in Ellis County.)

It seems Oklahoma physicians need to take off the blinders and heighten their index of suspicion.

Not surprisingly, children ages 1-3 comprise an unduly large number of children affected and the majority of deaths occurred in this group. The types of abhorrent treatment covered a wide gamut of behavior from lack of supervision and providing inadequate shelter and food to sexual abuse, beating, mental injury and even Munchausen Syndrome by proxy.

Surprisingly, the most frequent perpetrator was the mother (46.59%), with females of all categories being the perpetrator 60.42% of the time. The race of both the victim and the perpetrator appears to reflect closely that of the general population.

The most medically pertinent chart is that of the reporting source for this conduct. Only 1.18% of cases were reported by physicians. Most common was law enforcement - 17.36%, relatives - 15.16%, and school - 11.34%. It seems Oklahoma physicians need to take off the blinders and heighten their index of suspicion.

If you would like to learn more about detecting child abuse, one source is the OU Health Sciences Center's Center on Child Abuse and Neglect. Ask for Trish Williams at (405) 271-8858. (FAX 405/2712931).

Advice, continued from front page

In a recent case, a deaf patient successfully sued his physician for discrimination under the ADA after being discharged as a patient. The discharge occurred because the physician lost the only employee in his office who could communicate with the patient in sign language. The court held that instead of firing the patient, the physician should have made a reasonable effort to accommodate him by furnishing him written materials or using other methods to facilitate communication.

Before "firing" a patient, a physician should weigh carefully the potential risk for malpractice or discrimination lawsuits against the perceived benefits of firing a particular patient. If a decision is made to proceed, the physician should take the least amount of affirmative action possible to sever the relationship in order to avoid needlessly incurring the patient's ill will.

For example, one surgeon effectively terminated the physician-patient relationship while the patient was hospitalized awaiting a surgical procedure. After the patient refused to sign the proffered surgical consent form, the surgeon supplied the patient with a list of appropriate replacement surgeons. The court held that furnishing the list of substitute surgeons was a reasonable means of severing the physician-patient relationship where the patient's condition did not warrant immediate medical attention.

The following are some practical tips to consider when"firing" a patient:

When the patient calls to schedule his or her next routine appointment, determine if the patient is in need of immediate care and if the physician is presently involved in treating the patient for an ongoing illness. If these questions are answered in the negative, politely advise the patient that the physician no longer wishes to continue the relationship. Provide the patient with the telephone number of a referral service so that the patient may locate another appropriate physician. Document this conversation in the patient's file.

Use caution in sending written letters to terminate the physician-patient relationship. Ignore the natural urge to defend your decision or to provide too much information that might generate feelings of rancor in a patient. Letters may be useful to document unacceptable patient behavior, however, especially where warnings are given about the physician's intention to terminate the relationship if the unacceptable behavior continues. Be sure to include in the letter a referral to another competent physician or appropriate referral service.

Do not volunteer reasons for the physician's decision to sever the relationship. If asked, explain the circumstances without making accusations against the patient. Possible examples to consider are:

- "To reduce the doctor's heavy case load, he had to make some difficult decisions about which patients he could continue to see."
- "The doctor felt that you did not cooperate fully with her treatment during your prior illness and that you should see another physician."
- "The doctor has decided that he cannot keep you as a patient because of your unwillingness to pay promptly for his services."

Always remember that an ounce of prevention is worth a pound of cure. Before ending a troublesome physician-patient relationship, consider all possible adverse consequences and then take prudent steps to diffuse potential future complaints by handling the situation with common sense and diplomacy.

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July 8, 1997

DR

HELENA MT 59624

Re: Proper management of patient records when closing an office

Dear Dr. and Mr. :

For your reference I have enclosed copies of various publications on the pitfalls and proprieties of handling patient records when a physician leaves a practice site. These articles may represent current "standard of care." In a recent conversation, Mr. has stated that Dr. would like to withdraw his application for a permanent Montana license; we have received two out-of-state requests for verification of his current temporary license; I conclude that there is a possibility that Dr. may be leaving Butte and/or Montana.

Today I spoke with a woman who had called asking if it were legal for a doctor to leave town or state without notifying patients or providing a way for them to obtain refills of prescriptions he has been providing his patients. The woman stated that she had had an appointment with a psychiatrist in the last week of June. She stated she called his office on the Monday to confirm the exact date and time, and received only an answering machine recording that the physician was no longer seeing patients in , and callers should leave their names and the names of providers to whom they wished their records sent. The woman identified Dr. as the psychiatrist. She indicated she was on Doxepin, Lorazepam and Stelazine prescribed by Dr. for a number of months.

As you are aware, all three of those drugs can create some dependency; in patients where those drugs are necessary for mental or emotional stability, the withdrawal of those medications may be problematic for both the patient and the society which must deal with a patient in withdrawal or an unmedicated psychotic, neurotic or otherwise disabled mental state.

I assume that among Dr. many patients are those who like, this woman, have been receiving psychotropic medications and will continue to need them after Dr. departure from Montana, if that is indeed his plan. Unless their health care and records have been transferred to other Montana providers in an appropriate fashion before Dr. leaves, his patients will suffer a great deal, not only physically and mentally, but also from the administrative and legal chaos that will arise from lack of medical records in worker's compensation cases, disability cases, criminal cases, child custody cases, parole and competency hearings, drug and alcohol treatment cases, and a myriad of other contexts where psychiatric records are a necessary element for the processes of daily life.

I believe it probable that Montana courts would uphold a finding that failure to transfer patients and records appropriately was "conduct likely to . . . harm the public" (Rule 8.28.423, ARM; see also Rule 8.28.423(21), ARM), and "conduct that does not meet the generally accepted standards of practice." Section 37-1-316(18), MCA. If so, such conduct would be "unprofessional" (Section 37-1-316, MCA), and would constitute grounds for license denial (Section 37-1-312(1)(i) and Section 37-3-321, MCA), as well as license discipline (Section 37-1-312(1), MCA. Adverse decisions in such proceedings are, of course, reportable to the National Practitioner Data Bank and the Federation of State Medical Boards.

If Dr. is planning on terminating his and practices, and has not taken measures to effect the orderly transfer of his patients and their records other than the answering machine message described by this woman caller, please seriously consider implementing some of the procedures described in the enclosed articles, e.g., written notice to patients several months in advance (Rhode Island recommends 60-90 days), providing a local repository or custodian for patient records, some arrangements with nearby providers respecting on-going psychotropic medications or other treatments, etc. Many physicians terminating a practice contact their malpractice carrier to determine if the carrier has any particular requirements in order to better defend the physician in any subsequent malpractice actions.

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as all Board actions, was reported to the National Practitioner Data Bank, the Federation of State Medical Boards, and was provided to the local Montana newspaper and the Medical Board of the state to which the physician had moved. Most states have statutes which provide for reciprocal discipline.

Any information you would like to share with the Board concerning a closure of Dr. Montana practice and transfer of patients and records would be most appreciated.

Very truly yours,

PATRICIA I. ENGLAND
Executive Secretary

ISSUES and ANSWERS

MAY - 1 1998

Oklahoma State Board
of Medical Licensure
and Supervision

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Advice on Abandonment

by Susan Moebius Henderson,
Assistant Attorney General for the Board

Once a physician undertakes treatment of a patient, he or she has a continuing legal duty to treat that patient until the need for his or her services is at an end or until the physician-patient relationship is terminated lawfully. Physicians who improperly terminate a physician-patient relationship risk both civil lawsuits and charges of unprofessional conduct for patient abandonment.

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A physician must exercise reasonable and ordinary care in determining when the physician's services are no longer needed. Generally speaking, a physician must continue to provide services as long as the case requires it.

Unlike a patient, who may lawfully terminate the physician-patient relationship at any time, a physician may withdraw before the need for his or her services is at an end only after giving the patient prior notice. That notice must afford the patient ample opportunity to secure another equally competent physician prior to the withdrawal.

A patient who sues a physician for abandonment must prove that the abandonment caused the injury for which damages are being sought. For example, a physician incurred no liability for refusing to treat a patient some 16 days following initial treatment for a severely cut finger. After the finger became infected and was amputated, the patient sued the physician for abandonment. The court exonerated the physician because the refusal to treat occurred after the critical, initial period when immediate treatment necessary to save the finger was provided.

Abandonment has been justified in certain limited circumstances, such as where the patient has failed to cooperate in his or her treatment (e.g., failing to keep or reschedule appointments). One court held that a nephrologist had no legal obligation to continue dialysis treatment for an uncooperative patient where the patient was given sufficient notice that his treatment was being terminated and was provided with a list of other dialysis providers in the area.

Rural providers whose patients may have difficulty locating an equally competent replacement should be especially cautious when "firing" a patient. At least one rural physician has been forced to defend himself against potential violations of anti-trust law by denying healthcare services to a patient in an underserved area.

Courts traditionally have held that a patient's failure to pay for services will not justify abandonment if the patient still is in need of medical treatment.

Courts traditionally have held that a patient's failure to pay for services will not justify abandonment if the patient still is in need of medical treatment. For example, one physician was held liable for refusing to continue the treatment of a patient being prepared for emergency hand surgery until after the patient satisfied his outstanding account balance.

In a more recent case from Iowa, a physician was found not to have abandoned his patient by refusing to treat abscesses occurring subsequent to a gastric bypass. The surgeon's bookkeeper "fired" the patient for her failure to pay the bill for her surgery and follow up visits. The Iowa court found that the surgeon, who had seen the patient 11 times post-operatively and had previously advised her on treatment of the abscesses, was not liable because he did not abandon the patient during a critical stage of treatment.

From these cases, it appears that where a physician has successfully treated a patient's illness and has not been paid, he or she arguably may condition renewal of the physician-patient relationship on receipt of payment if the patient presents with a different illness that does not require immediate treatment.

Terminating a physician-patient relationship can be complicated further if the patient has a disability protected by the Americans with Disabilities Act (ADA) or the Federal Rehabilitation Act of 1973. The ADA prohibits places of public accommodation, such as physician offices, from discriminating against disabled individuals in the provision of goods and services.